



Facility Name & ID Number BIRCHWOOD PLAZA

# 0028696 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	200	Skilled (SNF)	200	73,200	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,200	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	41,827	15,075	2,534	59,436	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,827	15,075	2,534	59,436	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.20%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 6/17/84

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 6/17/84 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 200 and days of care provided 2,534

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **BIRCHWOOD PLAZA** # **0028696** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	230,343	31,503	10,421	272,267		272,267		272,267		1
2	Food Purchase		288,785		288,785	(21,814)	266,971	(1,338)	265,633		2
3	Housekeeping	232,541	41,404		273,945		273,945		273,945		3
4	Laundry	42,056	13,143	6,791	61,990		61,990		61,990		4
5	Heat and Other Utilities			153,763	153,763		153,763		153,763		5
6	Maintenance	43,390	20,115	53,433	116,938		116,938	679	117,617		6
7	Other (specify):*			6,918	6,918		6,918		6,918		7
8	<b>TOTAL General Services</b>	548,330	394,950	231,326	1,174,606	(21,814)	1,152,792	(659)	1,152,133		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			27,500	27,500		27,500		27,500		9
10	Nursing and Medical Records	2,098,038	138,544	14,643	2,251,225		2,251,225		2,251,225		10
10a	Therapy	100,889		32,438	133,327		133,327		133,327		10a
11	Activities	115,996	13,098	1,440	130,534		130,534		130,534		11
12	Social Services	4,577		4,820	9,397		9,397		9,397		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,319,500	151,642	80,841	2,551,983		2,551,983		2,551,983		16
	<b>C. General Administration</b>										
17	Administrative	201,706		692,053	893,759		893,759		893,759		17
18	Directors Fees										18
19	Professional Services			48,928	48,928		48,928		48,928		19
20	Dues, Fees, Subscriptions & Promotions			65,985	65,985		65,985	(48,939)	17,046		20
21	Clerical & General Office Expenses	122,426	12,577	33,280	168,283		168,283		168,283		21
22	Employee Benefits & Payroll Taxes			501,743	501,743	21,814	523,557		523,557		22
23	Inservice Training & Education			1,280	1,280		1,280		1,280		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			8,220	8,220		8,220		8,220		25
26	Insurance-Prop.Liab.Malpractice			186,303	186,303		186,303		186,303		26
27	Other (specify):* <b>MARKETING</b>	13,385			13,385		13,385		13,385		27
28	<b>TOTAL General Administration</b>	337,517	12,577	1,537,792	1,887,886	21,814	1,909,700	(48,939)	1,860,761		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,205,347	559,169	1,849,959	5,614,475		5,614,475	(49,598)	5,564,877		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	10,421
	REPAIRS & MAINTENANCE	0
	OUTSIDE SERVICES	0
		10,421
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	6,791
		0
		6,791
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	68,951
	ELECTRICITY	68,027
	WATER	16,736
	CABLE TV - LOBBY	49
		0
		153,763
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	2,035
	PAINTING & DECORATING	12,910
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	22,076
	ELEVATOR MAINTENANCE & REPAIR	7,364
	OUTSIDE LABOR	2,174
	EXTERMINATING SERVICE	2,700
	FIRE SERVICE	4,174
		0
		0
		0
		0
		53,433
7	<b>OTHER</b>	
	SCAVENGER	6,918
	SECURITY SERVICE	0
		0
		0
		6,918
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	27,500
		27,500

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	5,183
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	3,960
	PHARMACY CONSULTANT XVIII B 39-2	0
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	QUALITY CONTROL	5,500
		0
		14,643
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	32,438
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		32,438
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	920
	CLERGY	520
		1,440
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	4,820
		0
		4,820
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	692,053
	<b>DIRECTORS FEES</b>	
<b>18</b>	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	5,287
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	43,641
		0
		48,928
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	22,843
	EMPLOYEE WANT ADS XIX F	8,705
	CONTRIBUTIONS VI 20 XIX F	1,610
	DUES & SUBSCRIPTIONS XIX F	2,630
	LICENSES & PERMITS XIX F	4,521
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	24,086
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	400
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	400
	PATIENT BACKGROUND CHECKS XIX F	790
		65,985
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	6,251
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	27,029
	MESSENGER SERVICE	0
		0
		33,280

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	237,223
	UNEMPLOYMENT COMPENSATION XIX D	16,077
	WORKERS COMPENSATION INSURANC XIX D	62,260
	HOSPITALIZATION INSURANCE XIX D	159,877
	EMPLOYEE BENEFITS - OTHER XIX D	0
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	501 PLAN ADJUSTMENT XIX D	(1,456)
	CHICAGO HEAD TAX XIX D	4,336
	UNION PENSION XIX D	23,426
		501,743
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	1,280
		1,280
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	8,220
		8,220
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	186,303
		186,303
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,849,959

**BIRCHWOOD PLAZA  
SCHEDULES  
12/31/2008**

**PAGE 3 LINE 25  
TRANSPORTATION - STAFF**

**EMPLOYEE MEAL RECLASSIFICATION**

**PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	288,785
LESS SALES TAX	(1,338)
NET FOOD	<u>287,447</u>
TOTAL PATIENT CENSUS	59,436
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	<u>178,308</u>
ADD # EMPLOYEE MEALS/DAY	40
TIME # DAYS	366
TOTAL EMPLOYEE MEALS	<u>14,640</u>
PATIENT MEALS	178,308
ADD EMPLOYEE MEALS	14,640
TOTAL MEALS/YEAR	<u>192,948</u>
NET FOOD	287,447
DIVIDE TOTAL MEALS/YEAR	<u>192,948</u>
COST PER MEAL	1.49
TIME EMPLOYEE MEALS	14,640
EMPLOYEE MEAL RECLASSIFICATION	<u>21,814</u>
	=====

	NAME	PURPOSE	AMOUNT	AMOUNT
*****				
JAN	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		323.08
	CITIBANK AADVANTAFE	Gasoline for facility banking, maintenance, marketing & activities	58.31	
	SCHAUFELBERGER	Phone	(16.08)	
FEB	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		323.08
	CITI BANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	222.09	
	CESARS CORIA	Gasoline for facility banking, maintenance, marketing & activities	25.00	
MAR	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		323.08
	CITI BANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	298.24	
	DOBSON PLAZA	LICENSE	78.00	
	SEC OF STATE	LICENSE	78.00	
APR	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		484.62
	CESARS CORIA	Gasoline for facility banking, maintenance, marketing & activities	30.00	
	CITI BANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	161.61	
MAY	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		323.08
	CITI BANK AADVATAGE	Gasoline for facility banking, maintenance, marketing & activities	142.38	
	BEE ZEE SERVICE	Gasoline for facility banking, maintenance, marketing & activities	25.00	
JUN	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		323.08
	CITIBANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	453.99	
	CITIBANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	192.84	
JUL	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		323.08
	CITIBANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	289.71	
	AMER EXPRESS	Gasoline for facility banking, maintenance, marketing & activities	83.44	
AUG	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		484.62
	CITIBANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	314.19	
	ABRAHAM SCHIFFMAN	Gasoline for facility banking, maintenance, marketing & activities	97.76	
SEP	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		161.54
	CITIBANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	35.00	
	PETTY CASH	Gasoline for facility banking, maintenance, marketing & activities	234.44	
OCT	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		484.62
	CITIBANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	130.09	
NOV	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		323.08
	CITIBANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	199.01	
	DOBSON PLAZA	Gasoline for facility banking, maintenance, marketing & activities	75.00	
	SAMS CLUB	Gasoline for facility banking, maintenance, marketing & activities	63.64	
DEC	JOYCE GRODETZ	MONTHLY AUTO REIMBURSEMENT		484.62
	PETTY CASH	Gasoline for facility banking, maintenance, marketing & activities	25.00	
	CITIBANK AADVANTAGE	Gasoline for facility banking, maintenance, marketing & activities	206.82	
	ABRAHAM SCHIFFMAN	Gasoline for facility banking, maintenance, marketing & activities	7.50	
	ROBERT SETA	Gasoline for facility banking, maintenance, marketing & activities	275.00	
	SAMS CLUB	Gasoline for facility banking, maintenance, marketing & activities	31.84	
	PETTY CASH	Gasoline for facility banking, maintenance, marketing & activities	40.48	
TOTAL			<u>3,858.30</u>	<u>4,361.58</u>
			=====	=====
		<b>TOTAL STAFF TRANSPORTATION</b>	<b>8,219.88</b>	
			=====	

Facility Name & ID Number **BIRCHWOOD PLAZA**

#0028696

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			10,960	10,960		10,960	110,852	121,812			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,827	13,827		13,827	322,435	336,262			32
33	Real Estate Taxes			178,542	178,542		178,542	(3,841)	174,701			33
34	Rent-Facility & Grounds			438,000	438,000		438,000	(438,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* <b>STORAGE</b>			1,529	1,529		1,529		1,529			36
37	<b>TOTAL Ownership</b>			642,858	642,858		642,858	(8,554)	634,304			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		136,886	64,407	201,293		201,293		201,293			39
40	Barber and Beauty Shops			7,427	7,427		7,427		7,427			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,800	109,800		109,800		109,800			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		136,886	181,634	318,520		318,520		318,520			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,205,347	696,055	2,674,451	6,575,853		6,575,853	(58,152)	6,517,701			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **BIRCHWOOD PLAZA**

# **0028696**

Report Period Beginning:

**01/01/2008**

Ending:

**12/31/2008**

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,852)	30		9
10	Interest and Other Investment Income	(2,803)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,338)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(400)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,610)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(22,843)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(24,086)	20		28
29	Other-Attach Schedule	(3,162)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (58,094)</b>		<b>\$</b>	<b>30</b>

<b>BHF USE ONLY</b>							
48		49		50		51	

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(58)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (58)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (58,152)</b>		<b>37</b>

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BIRCHWOOD PLAZA

ID# 0028696

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 679	6	1
2				2
3	POST-CLOSING ACCRUAL			3
4	OVERPAID 2007 REAL ESTATE TAX	(3,841)	33	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(3,162)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number BIRCHWOOD PLAZA# 0028696

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,338)	0	0	0	0	0	0	0	0	0	0	(1,338)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	679	0	0	0	0	0	0	0	0	0	0	679	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(659)</b>	<b>0</b>	<b>(659)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(48,939)	0	0	0	0	0	0	0	0	0	0	(48,939)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(48,939)</b>	<b>0</b>	<b>(48,939)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(49,598)</b>	<b>0</b>	<b>(49,598)</b>	<b>29</b>									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BIRCHWOOD PLAZA

# 0028696

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,852)	112,704	0	0	0	0	0	0	0	0	0	110,852	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,803)	325,238	0	0	0	0	0	0	0	0	0	322,435	32
33	Real Estate Taxes	(3,841)	0	0	0	0	0	0	0	0	0	0	(3,841)	33
34	Rent-Facility & Grounds	0	(438,000)	0	0	0	0	0	0	0	0	0	(438,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(8,496)</b>	<b>(58)</b>	<b>0</b>	<b>(8,554)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(58,094)</b>	<b>(58)</b>	<b>0</b>	<b>(58,152)</b>	<b>45</b>								

Facility Name & ID Number

**BIRCHWOOD PLAZA**

# **0028696**

Report Period Beginning:

**01/01/2008**

Ending:

**12/31/2008**

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		<b>DOBSON PLAZA INC</b>	<b>EVANSTON, IL</b>	<b>BIRCHWOOD PLAZA ASSOCIATES</b>	<b>CHICAGO</b>	<b>REAL ESTATE RENTAL</b>
	<b>SEE ATTACHED</b>					

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	<b>34 RENT</b>	<b>\$ 438,000</b>	<b>BIRCHWOOD PLAZA ASSOCIATES</b>		<b>\$</b>	<b>(438,000)</b>	<b>1</b>
2	V	<b>30 SL DEPRECIATION</b>		<b>" "</b>		<b>112,704</b>	<b>112,704</b>	<b>2</b>
3	V	<b>32 INTEREST</b>		<b>" "</b>		<b>325,238</b>	<b>325,238</b>	<b>3</b>
4	V							<b>4</b>
5	V							<b>5</b>
6	V							<b>6</b>
7	V							<b>7</b>
8	V							<b>8</b>
9	V							<b>9</b>
10	V							<b>10</b>
11	V							<b>11</b>
12	V							<b>12</b>
13	V							<b>13</b>
14	<b>Total</b>		<b>\$ 438,000</b>			<b>\$ 437,942</b>	<b>\$ * (58)</b>	<b>14</b>

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number

BIRCHWOOD PLAZA

#

0028696

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	<u>CHARLOTTE KOHN</u>	<u>EXEC. DIRECTOR</u>	<u>MGMT CONSULT</u>	<u>0.00</u>	<u>65,143</u>	<u>27</u>	<u>45.00</u>	<u>MGMT FEES</u>	<u>\$ 692,053</u>	<u>17-3</u>	<u>1</u>
2											<u>2</u>
3											<u>3</u>
4											<u>4</u>
5											<u>5</u>
6											<u>6</u>
7											<u>7</u>
8											<u>8</u>
9											<u>9</u>
10											<u>10</u>
11											<u>11</u>
12											<u>12</u>
13								<b>TOTAL</b>	<b>\$ 692,053</b>		<b>13</b>

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number **BIRCHWOOD PLAZA**

# **0028696** Report Period Beginning: **01/01/2008** Ending: **2/31/2008**

**VIII. ALLOCATION OF INDIRECT COSTS**

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name &amp; ID Number

BIRCHWOOD PLAZA

# 0028696

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1	<b>RELATED PARTY - BIRCHWOOD PLAZA ASSOCIATES:</b>						\$	\$			\$	1						
2	<b>MB FINANCIAL</b>		X	<b>MORTGAGE</b>	<b>\$43,274.00</b>	<b>3/1/2004</b>	<b>6,000,000</b>	<b>5,148,230</b>	<b>3/5/2009</b>	<b>6.0000</b>	<b>320,691</b>	2						
3	<b>TITLE &amp; LOAN FEES</b>		X	<b>AMORTIZED OVER 5 YRS</b>		<b>3/1/2004</b>	<b>22,737</b>	<b>1,138</b>			<b>4,547</b>	3						
4	<b>LESS RELATED PARTY INTEREST INCOME</b>											4						
5	<b>HONDA FINANCE</b>		X	<b>AUTO LOAN</b>	<b>\$991.29</b>	<b>4/5/2006</b>	<b>52,657</b>		<b>4/5/2011</b>	<b>4.9000</b>	<b>1,101</b>	5						
	<b>Working Capital</b>																	
6	<b>ABRAHAM SCHIFFMAN</b>	X		<b>INSURANCE FINANCING</b>	<b>\$17,739.09</b>	<b>06/01/07</b>	<b>115,999</b>		<b>06/01/08</b>		<b>6,730</b>	6						
7	<b>ABRAHAM SCHIFFMAN</b>	X		<b>INSURANCE FINANCING</b>	<b>\$15,436.67</b>	<b>06/01/08</b>	<b>185,240</b>	<b>92,620</b>	<b>06/01/09</b>	<b>5.2500</b>	<b>4,673</b>	7						
8	<b>HARRIS BANK</b>		X	<b>AUTO LOAN</b>	<b>\$962.27</b>	<b>08/12/08</b>	<b>56,140</b>	<b>53,614</b>	<b>08/12/14</b>	<b>7.1900</b>	<b>1,323</b>	8						
9	<b>TOTAL Facility Related</b>				<b>\$78,403.32</b>		<b>\$ 6,432,773</b>	<b>\$ 5,295,602</b>			<b>\$ 339,065</b>	9						
	<b>B. Non-Facility Related*</b>																	
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						<b>\$</b>	<b>\$</b>			<b>\$</b>	14						
15	<b>TOTALS (line 9+line14)</b>						<b>\$ 6,432,773</b>	<b>\$ 5,295,602</b>			<b>\$ 339,065</b>	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # \_\_\_\_\_\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.	\$	<b>176,310</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<b>172,701</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(3,609)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>178,310</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>174,701</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2003</b>	<b>167,404</b>	<b>8</b>
	<b>2004</b>	<b>171,122</b>	<b>9</b>
	<b>2005</b>	<b>172,865</b>	<b>10</b>
	<b>2006</b>	<b>174,865</b>	<b>11</b>
	<b>2007</b>	<b>172,701</b>	<b>12</b>

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2007	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 103% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2007 TAX BILL.**

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME BIRCHWOOD PLAZA COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0028696

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE ( 847 ) 675-3585 FAX #: ( 847 ) 675-5777

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-29-302-011-0000</u>	<u>NURSING HOME</u>	\$ <u>3,814.92</u>	\$ <u>3,814.92</u>
2. <u>11-29-302-012-0000</u>	<u>NURSING HOME</u>	\$ <u>74,648.41</u>	\$ <u>74,648.41</u>
3. <u>11-29-302-020-0000</u>	<u>NURSING HOME</u>	\$ <u>94,237.73</u>	\$ <u>94,237.73</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>172,701.06</u>	\$ <u>172,701.06</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        X        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number BIRCHWOOD PLAZA

# 0028696

Report Period Beginning:

01/01/2008 Ending:

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**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: \_\_\_\_\_ B. General Construction Type: Exterior BRICK Frame STEEL & CONCRETE Number of Stories \_\_\_\_\_

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>RELATED PARTY: BIRCHWOOD PLAZA ASSOC</u>			\$	1
2	<u>NURSING HOME</u>		<u>1984</u>	<u>80,569</u>	2
3	<b>TOTALS</b>			\$ <b>80,569</b>	3

Facility Name & ID Number **BIRCHWOOD PLAZA**# **0028696**

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4		<b>RELATED PARTY: BIRCHWOOD PLAZA ASSOC</b>			\$	\$		\$	\$	\$	4
5	192		1984		2,238,672		40	55,967	55,967	1,409,193	5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		CONCRETE PAVING & RAILS	1984		13,495		20			13,495	9
10		SPRINKLER MODIFICATION	1984		2,752		25	110	110	2,690	10
11		LOBBY RENOVATION	1984		2,489		40	62	62	1,536	11
12		TERRACE RESURFACE	1984		7,600		15			7,600	12
13		FOYER RE-FLOORING	1984		1,835		20			1,835	13
14		BASEMENT RENOVATION	1985		18,061		40	452	452	11,259	14
15		NURSING STATION REMODELLING	1985		7,755		20			7,755	15
16		ASPHALT ROOF	1985		7,000		15			7,000	16
17		NURSE CALL SYSTEM REWIRE	1985		4,066		15			4,066	17
18		SPRINKLER MODIFICATION	1985		2,963		25	119	119	2,762	18
19		BASEMENT AWNINGS	1985		1,620		15			1,620	19
20		GRAVEL ROOF	1985		2,700		5			2,700	20
21		CEILING BASEMENT NURSING OFFICE	1985		1,200		20			1,200	21
22		ELEVATOR OVERHAUL	1985		12,800		20			12,800	22
23		VARIOUS (ELECTRIC & SPRINKLER)	1986		5,486		20			5,486	23
24		ELECTRIC PANEL	1988		6,000	190	20	260	70	6,000	24
25		ELECTRICAL IMPROVEMENTS	1990		1,200	38	20	60	22	1,098	25
26		ELEVATOR IMPROVEMENTS	1990		15,600	495	20	780	285	14,405	26
27		TUCKPOINTING & BRICKWORK	1990		12,300	390	20	615	225	10,897	27
28		LAUNDRY ROOM DUCTWORK	1990		3,000	95	20	150	55	2,670	28
29		BUILDING EXTENSION FOR OFFICE/ACT.ROOM/DR	1994		282,054	7,336	20	14,103	6,767	210,147	29
30		DRAPERY	1994		7,933		5			7,933	30
31		ROOF & PARKING LOT IMPROVEMENTS	1995		69,984	1,992	15	4,666	2,674	61,087	31
32		ENLARGE PATIENT ROOMS(TRANS TO XI-C 97 AUDIT)	1997			149	39		(149)		32
33		WINDOWS	1998		41,775	615	25	1,671	1,056	18,381	33
34		SIDING	1998		20,000	513	25	800	287	8,800	34
35		PATIENT ROOM EXHAUST SYSTEM	1998		9,720	486	20	486		4,941	35
36		ELEVATOR SAFETY DEVICES	1998		5,350	357	15	357		3,689	36

\*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name &amp; ID Number BIRCHWOOD PLAZA

# 0028696

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	BUILDING EXTENSION (1994) ALLOWED FOR 1998	1998	\$ 49,866	\$	20	\$ 2,493	\$ 2,493	\$ 27,423	37
38	ROOFTOP A/C	1999	58,870	1,509	39	1,509		14,335	38
39	LIGHTING/HAND RAILS/FLOORING/DRAPES	1999	27,264	699	39	699		6,641	39
40	CARPETING / DRAPERIES	2000	5,062	227	7		(227)	5,062	40
41	A/C SYSTEM	2000	6,395	233	27.5	233		2,009	41
42	WATER LINES, VENTING & HEATING IRON RAILING	2001	5,165	188	27.5	188		1,433	42
43	ELEVATOR UPGRADE / FRONT OUTDOOR WALL SYSTEM	2001	89,217	3,244	27.5	3,244		24,736	43
44	CARPETING	2001	8,264		7	588	588	8,264	44
45	DRAPERIES	2001	7,753		7	1,105	1,105	7,753	45
46	WALLPAPER / CARPETTING	2002	18,309	739	7	2,616	1,877	17,004	46
47	NURSES STATION	2002	15,101	549	27.5	549		3,637	47
48	WALLPAPER / ELEVATOR UPGRADE	2003	13,835	503	27.5	503		2,902	48
49	WALLPAPER / CARPENTRY	2004	46,774	1,701	27.5	1,701		7,083	49
50	WALLPAPER / CARPENTRY / REMODELING	2005	18,014	655	27.5	655		2,281	50
51	CIRCULATING PUMP	2005	4,139	151	27.5	151		509	51
52	PHONE SYST/WALLPAPER/FLOOR/CARPENTRY/REMODELING	2006	13,703	498	27.5	498		1,453	52
53	FIRE SUPPRESSION SYST/LIGHT FIXTURES	2006	5,719	208	27.5	208		546	53
54	ELEV DOOR RESTRICTOR/PUMP/SENSORS	2006	6,784	247	27.5	247		628	54
55	GREASE TRAP/PLUMBING/CONCRETE/THRU-WALL A/C'S	2006	12,014	437	27.5	437		1,074	55
56	NURSING STATION/KITCHEN TILE	2006	14,907	542	27.5	542		1,209	56
57	NURSING STATION/FLOORING/LIGHTING/THRU-WALL A/C'S	2007	17,283	628	27.5	628		1,059	57
58	FLOORING/CARPETING/WALLPAPER	2007	20,700	6,624	7	2,957	(3,667)	4,436	58
59	LL OFFICE/BATHRMS/TILE/LOCKS/WIRING/THRU-WALL A/C	2008	45,488	714	27.5	714		714	59
60	CARPETING	2008	2,030	1,167	7	145	(1,022)	145	60
61									61
62									62
63									63
64									64
65	ADJ TO SL			69,149			(69,149)		65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,318,066	\$ 103,268		\$ 103,268	\$	\$ 1,985,381	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 94,336	\$ 8,731	\$ 8,731	\$	5-15 YRS	\$ 56,843	71
72	Current Year Purchases	15,575	705	705		8-15 YR	705	72
73	Fully Depreciated Assets							73
74	FROM XI-B (97 AUDIT)	14,550				10 YRS	14,550	74
75	TOTALS	\$ 124,461	\$ 9,436	\$ 9,436	\$		\$ 72,098	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	BANKING,PURCHASING,	'09 ACURA	2008	\$ 91,079	\$ 10,960	\$ 9,108	\$ (1,852)	10 YRS	\$ 9,108	76
77	ADMINISTRATIVE,ETC									77
78										78
79	FACILITY VAN		1998	13,600				4 YRS	13,600	79
80	TOTALS			\$ 104,679	\$ 10,960	\$ 9,108	\$ (1,852)		\$ 22,708	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,627,775	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 123,664	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 121,812	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,852)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,080,187	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: **N/A - RELATED PARTY**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>		

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 57,461	\$		\$ 57,461	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			101			101	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			6,845			6,845	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				124,957		124,957	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	RADIOLOGY/LAB/MEDICAL SUPPLIES Other (specify):	39-2					11,929		11,929	13
14	<b>TOTAL</b>			\$		\$ 64,407	\$ 136,886		\$ 201,293	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **BIRCHWOOD PLAZA**  
**XV. BALANCE SHEET - Unrestricted Operating Fund.**

# **0028696**  
 As of **12/31/2008**

Report Period Beginning: **01/01/2008**  
 (last day of reporting year)

Ending: **12/31/2008**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 8,095	\$ 57,061	1
2	Cash-Patient Deposits	96,471	96,471	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	2,472,568	2,472,568	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments		25,211	5
6	Prepaid Insurance	80,267	80,267	6
7	Other Prepaid Expenses	6,141	6,141	7
8	Accounts Receivable (owners or related parties)	3,509	813,509	8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,667,051	\$ 3,551,228	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		80,569	13
14	Buildings, at Historical Cost		2,232,597	14
15	Leasehold Improvements, at Historical Cost		1,101,276	15
16	Equipment, at Historical Cost	91,079	214,590	16
17	Accumulated Depreciation (book methods)	(10,960)	(2,804,618)	17
18	Deferred Charges		1,138	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>NY LIFE INSUR.CONTRACTS</u>	340,500	340,500	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 420,619	\$ 1,166,052	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,087,670	\$ 4,717,280	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 275,605	\$ 275,605	26
27	Officer's Accounts Payable	295,019	295,019	27
28	Accounts Payable-Patient Deposits	96,471	96,471	28
29	Short-Term Notes Payable	100,571	5,248,801	29
30	Accrued Salaries Payable	107,080	107,080	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,668	12,668	31
32	Accrued Real Estate Taxes(Sch.IX-B)		178,310	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>DEFERRED INCOME</u>	275,621	275,621	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,163,035	\$ 6,489,575	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	45,663	45,663	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	235,925	235,925	42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>DUE TO BP ASSOC</u>	139,875		43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 421,463	\$ 281,588	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,584,498	\$ 6,771,163	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,503,172	\$ (2,053,883)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,087,670	\$ 4,717,280	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,009,092</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>2007 IL REPLACEMENT TAX</b>	(29,258)	<b>3</b>
<b>4</b>	<b>ROUNDING</b>	2	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>979,836</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	2,163,336	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(1,640,000)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>523,336</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,503,172</b>	<b>24</b> *

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 8,518,138	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,518,138	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	218,248	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 218,248	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	2,803	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,803	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,739,189	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,174,606	31
32	Health Care	2,551,983	32
33	General Administration	1,887,886	33
	<b>B. Capital Expense</b>		
34	Ownership	642,858	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	208,720	35
36	Provider Participation Fee	109,800	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,575,853	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	2,163,336	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 2,163,336	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **BIRCHWOOD PLAZA**

# 0028696

Report Period Beginning: 01/01/2008

Ending:

12/31/2008

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	3,978	4,408	\$ 169,265	\$ 38.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,450	23,623	775,003	32.81	3
4	Licensed Practical Nurses	9,070	9,401	242,244	25.77	4
5	CNAs & Orderlies	70,011	75,969	889,279	11.71	5
6	CNA Trainees					6
7	Licensed Therapist	4,542	5,096	100,889	19.80	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,198	10,410	115,996	11.14	10
11	Social Service Workers	224	224	4,577	20.43	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,878	2,187	45,998	21.03	14
15	Cook Helpers/Assistants	6,280	7,077	86,425	12.21	15
16	Dishwashers	10,015	10,872	97,920	9.01	16
17	Maintenance Workers	1,880	2,049	43,390	21.18	17
18	Housekeepers	18,596	20,642	232,541	11.27	18
19	Laundry	4,083	4,585	42,056	9.17	19
20	Administrator	1,478	1,478	141,678	95.86	20
21	Assistant Administrator	2,091	2,091	60,028	28.71	21
22	Other Administrative					22
23	Office Manager	1,829	1,859	42,867	23.06	23
24	Clerical	4,620	4,836	79,559	16.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: MDS CLERK/QA	892	897	22,247	24.80	32
33	Other(specify) <u>MARKETING</u>	464	464	13,385	28.85	33
34	TOTAL (lines 1 - 33)	174,579	188,168	\$ 3,205,347 *	\$ 17.03	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 10,421	1-3	35
36	Medical Director	O	27,500	9-3	36
37	Medical Records Consultant	N	3,960	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	920	11-3	44
45	Social Service Consultant	E	4,820	12-3	45
46	Other(specify)	S			46
47	<u>QUALITY CONTROL</u>				47
48					48
49	TOTAL (lines 35 - 48)		\$ 47,621		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	41	\$ 1,636	10-3	50
51	Licensed Practical Nurses	137	3,436	10-3	51
52	Certified Nurse Assistants/Aides	7	111	10-3	52
53	TOTAL (lines 50 - 52)	185	\$ 5,183		53

Facility Name & ID Number **BIRCHWOOD PLAZA**

# **0028696**

Report Period Beginning: **01/01/2008**

Ending: **12/31/2008**

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
ABRAHAM SCHIFFMAN	ADMINISTRATOR		\$ 141,678	Workers' Compensation Insurance	\$ 62,260	IDPH License Fee	\$ 996	
JOYCE GRODETZ	ASST ADMIN		60,028	Unemployment Compensation Insurance	16,077	Advertising: Employee Recruitment	8,705	
			0	FICA Taxes	237,223	Health Care Worker Background Check	400	
				Employee Health Insurance	159,877	(Indicate # of checks performed <u>40</u> )		
				Employee Meals	21,814	Patient Background Checks	79	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	2,010	
				EMPLOYEE BENEFITS - OTHER	0	MARKETING/ADV/PROMO	46,929	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	6,155	
				PENSION/PROFIT SHARING PLANS	(1,456)			
				CHICAGO HEAD TAX	4,336	TRUST/FRANCHISE/CONTRIB/ETC	(2,010)	
				UNION PENSION	23,426	Less: Public Relations Expense	( 0 )	
						Non-allowable advertising	(22,843)	
						Yellow page advertising	(24,086)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 201,706	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 523,557		\$ 17,046		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
CHARLOTTE KOHN	MANAGEMENT FEES		\$ 692,053				Out-of-State Travel	\$
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 692,053				Seminar Expense	0
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 48,928	TOTAL		\$	TOTAL	\$

\* Attach copy of IMRF notifications

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008
1	<b>PAINT/DECORATING</b>	<b>2005</b>	<b>\$ 4,075</b>	<b>3</b>	<b>\$ 680</b>	<b>\$ 1,358</b>	<b>\$ 1,358</b>	<b>\$ 679</b>	\$	\$	\$	\$								
2																				
3																				
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20	<b>TOTALS</b>		<b>\$ 4,075</b>		<b>\$ 680</b>	<b>\$ 1,358</b>	<b>\$ 1,358</b>	<b>\$ 679</b>	\$	\$	\$	\$								

Facility Name & ID Number **BIRCHWOOD PLAZA**# **0028696**Report Period Beginning: **01/01/2008**Ending: **12/31/2008****XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 54,611 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 109,800  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 21,814 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. **Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees